Outpatient Rehabilitation Agency Public Meeting
October 8, 2009
2:00 p.m.
Meeting Minutes

Attendees:

DMAS Staff		
Senthia Barlow	William Butler	Qaiyim Cheeseborough
Bill Lessard	Eileen Miller	Carla Russell
Barbara Seymour	Tammy Whitlock	Kelli Eaton

Members of the Public		
Lisa Cox	Jan Jessee	Molly Zarski

1. Introductions

Bill Lessard, DMAS Provider Reimbursement Director, introduced himself and stated the reason for the meeting was to review the proposed regulations for outpatient rehabilitation. Mr. Lessard gave an overview of the general structure of the meeting, stating that he would give an overview of the regulations and then allow a period for comments from the other attendees.

2. Regulation Overview

Mr. Lessard explained that there are two regulatory processes happening simultaneously:

a. The proposed regulation initiated in early July
b. The emergency regulation effective July 2, 2009 for reimbursement services implemented in the same month

Jan Jessee, of Professional Therapies of Roanoke, expressed confusion as to why there were two regulations at the same time. Mr. Lessard explained that initially the goal was to implement the reimbursement methodology in a budget neutral manner; however, an emergency regulation was needed to implement the budget reduction. Mr. Lessard also stated that DMAS received comments on the proposed regulation, which were summarized in the letter sent to rehabilitation agencies dated September 24, 2009. As a result of the comments, a formal public meeting was required. Mr. Lessard stated that additional meetings with providers can be arranged if providers wish to discuss the matter in more detail. He explained that a decision will not be made today, and that DMAS' response will be included with the final regulation.

Ms. Jessee inquired whether or not the Provider Reimbursement division at DMAS created the budget items and, if not, whose responsibility it is. Mr. Lessard explained that the budget line items come from many different sources and at times, Provider Reimbursement is asked to contribute. Ms. Jessee then asked if DMAS is given a target budget figure that the agency must meet. As a follow-up to that question, she asked how did DMAS arrive at the budget reduction for physical therapy (PT). Mr. Lessard stated that the agency has been

asked to come up with a number of budget reductions but that final decisions about specific budget amendments are not made by DMAS. does not determine a specific amount. He then opened up the meeting to public comment.

3. Public Comments

Jan Jessee read a statement, which is attached, that focused on the inappropriateness of using CPT codes for billing in the manner prescribed by DMAS. She also distributed supporting documentation.

After Ms. Jessee read her statement, Molly Zarski, of Albemarle Therapy Center, introduced herself and explained her concerns. According to Ms. Zarski, the main concerns for her organization are the rates for speech therapy. She stated that the number of Medicaid children they serve has dramatically increased. She went on to say that particularly in the Charlottesville area speech therapists need to have specialized skills that regular speech therapists do not possess. Further compounding this situation is the fact that many of the children are not getting the services they need from the schools and so it is falling upon Ms. Zarski's organization and others like it to provide these services.

Jan Jessee also stated that the pre-authorizations are another area for concern. She stated that the ARS or MediCall system does not tell them when someone is in Medallion II or fee for service and that this causes backlogs in adjudication due to the fact that the MCOs do not allow reciprocity of the PA.

Molly Zarski also stated that therapists offering private pay services in the Charlottesville are a major source of competition for them. Jan Jessee stated that there is already a lot of paperwork that is required of Medicaid therapy providers for such low reimbursement while there are private therapists that go to a client's home and get an immediate payment for an hour of service.

Lisa Cox, of ARC, expressed a desire for speech therapy to have a higher reimbursement rate. She further explained that they cannot have a child go off and do PT or OT while doing speech therapy and then come back to check on them. According to Ms. Cox, speech therapy is too intensive to be broken up like that. Jan Jessee added that the speech therapy rates can only be cut so much before it is no longer feasible for speech providers to keep the doors open.

4. Discussion

Mr. Lessard then took a few moments to explain that often policy is driven by operational considerations and that prior authorization was a significant operational consideration in this matter. The most problematic issue regarding PA is how to prior authorize up to 30 CPT codes when the PA system is designed on a visit basis. It is unclear how to pre-authorize using modalities because it is more difficult to define how many modalities qualify as a visit.

Jan Jessee made the suggestion of returning to revenue code billing, which she stated would allow accurate coding for all payer sources. Mr. Lessard explained that should the agency decide to return to revenue code-based billing, they would still want to set rates as opposed to having these services subject to cost settlement.

Mr. Lessard explained that changes in the speech therapy rates cannot be done in a budget neutral manner without compensating changes in the physical and occupational therapy rates.

In addressing the coding issue Ms. Jessee raised in her statement, Mr. Lessard stated that DMAS makes a number of modifications to HCPCS and the outpatient rehab change is not that dissimilar from previous changes for other providers. In the instances where DMAS billing incorporates HCPCS modifications, an effort is made to include detailed billing instructions.

Eileen Miller, of DMAS, stated that as long as providers are billing in accordance with DMAS' regulations, it is not fraudulent. Ms. Jessee countered that it is fraudulent from the Virginia Physical Therapy Association's viewpoint and that coding the way DMAS wants them to could result in a loss of licensure as it goes against VPTA's directive for accurate coding and violates their Principles of Ethical Standards. Mr. Lessard explained that the codes covered were a policy decision and not dictated by the regulations. He also explained that the significant system changes required to allow for billing of all outpatient rehab codes would take an indefinite amount of time and certainly more than a year to implement. The reason is that only emergency changes can be made to the MMIS during the takeover of a new contractor.

In response to the issue Ms. Jessee raised about the cost of provider systems changes mandated by the change in reimbursement methodology, Mr. Lessard acknowledged the one time cost. Once changes are made, many providers may prefer to keep the new system rather than change again.

Mr. Lessard ended by saying that DMAS greatly appreciates provider feedback. He offered to meet with the Virginia Physical Therapy Association, who were not able to attend the public meeting.

4. Adjourn

Statement Regarding Coding Issues Under Proposed Medicaid Methodology
October 8,2009

My name is Jan Jessee. I am a Physical Therapist and the founder of Professional Therapies of Roanoke, Inc.. We are a Certified Rehabilitation Agency employing 47 therapists providing Physical, Speech, and Occupational Therapy Services. We have provided these services to the citizens of Southwest Virginia for the past 25 years, and we have been providing Medicaid services since the inception of our Company.

Thank you for giving me the opportunity to speak to you today. I am expressing concerns of my Agency as well as many other Rehab. Agency personnel with whom I have spoken. I am also reporting on the concerns expressed to me by Virginia Physical Therapy Association representatives including Julia Rice, executive director, Terry Ferrier, president, and Angela Brooks, reimbursement representative. These individuals, as you know, are involved today in the annual state-wide Physical Therapy Convention, and have asked to speak with you at another time.

The main concern we have (aside from the reduction in reimbursement rates) is our inability to correctly report the services we perform when we bill DMAS. With the proposed methodology, DMAS is asking is asking us to provide one service (such as traction or hot packs), and report it for billing purposes as therapeutic exercise. The DMAS background document states that these codes are broad enough to"encompass all the rehabilitation services performed by rehab agencies" and further that "it is no different than the number of codes available to providers billing currently". The only current providers who utilize this limited code structure are Schools whose services are not as broad as office based services. In our offices, we provide many more modalities such as electrical stimulation, whirlpool, iontophoresis, ultrasound, splinting, taping, massage, manual therapy, etc., etc. Whereas we have , in Rehab Agencies, been using the revenue codes for which you provided the crosswalk, those revenue codes are, in fact, global codes that are a part of the HCPCS system and are adjuncts to the CPT4 Level I codes which are more specific, and which we use for all other payors.

I have provided to you a couple of pages of background information regarding CPT Coding, HCPCS, and our legal requirements. CPT4 and HCPCS codes, as stated in the literature, are meant to meet operational needs of both Medicare AND Medicaid. They were established to allow providers to communicate their services in a consistent manner. Section 1834 K5 (pgs. 3-5 of your packet) states that "For claims for services submitted on or after April 1, 1998....the claim shall include a code under a uniform coding system specified by the Secretary that identifies the services furnished". In the CMS news release of October 6, 2004 it is stated that the codes are utilized not only by Medicare but by Medicaid. It further states that " initially the use of the codes was voluntary, but with the implementation of the HIPAA in 1996, use of the HCPCS for transactions involving health care information became mandatory."

In addition to the coding, we also have real concerns about the rate structure particularly for Speech Services. Whereas, we understand that item 306XX of Chapter 781 of the 2009 Appropriations Act states that there needs to be approximately $372000.00 in savings the second year of this change, there is really no way to accurately predict future claims. Conservatively, 50% of the Rehab Agency claims will now be moved to the EPSDT system under Early Intervention. In the DMAS Town Hall Background information TH-02, it states that DMAS will save close to $50000.00 per year by not having to adjudicate our cost reports. In addition, the minutes of the DMAS Board of Director's Meeting on March 10,2009 state that new ARRA funds will be used to restore proposed decreases, and that the federal matching rate for Virginia which has been 50% will be increasing to 56.85% and 60.19% respectively in each of the next two years. This significantly decreases the cost to DMAS for ALL of our services. Further, the DMAS Town Hall General Notice of May 6,2009 stated that our decreased reimbursement would achieve a $.4 million savings which is equivalent to NOT receiving an inflationary adjustment. Therefore, in trying to project the future expenditure, DMAS should not have tried to reduce payments from the current year because all that was necessary was to not take an inflationary increase. The savings and the federal matching increases more than make up for the need for cuts.

In addition, as a number of Speech Pathologists have said, the 92507 code, which DMAS proposes we use for ALL Speech Services other than evaluation and group, has been most consistently used in hospitals for bedside treatments which last typically anywhere from 15 to 30 minutes. Most of the Speech Services in Rehab. Agencies have been 45 minutes to an hour or longer. DMAS proposes paying only $58.88 for our longer rehab services. This rate represents only 93% of the Medicare rates while the higher rates will be paid by Medicare for the shorter hospital visits since Medicare is the payor for most Hospital services. Also, while Rehab. Agencies will be receiving $58.88 for each session no matter how long it lasts, a 15 to 30 minute session in the School System is being reimbursed at an average of $290.00. We were told Tuesday, at the Statewide DMAS/DOE Training that some of these School therapy sessions are being reimbursed at $2400.00 each!!! That does not comport with federal guidelines and promulgated regulations requiring cost effective and efficient service provision and makes no sense when the Rehab. Agencies are truly providing the medical services which DMAS was established to pay.

We are asking that we be allowed to use all of our appropriate and correctly applied CPT4 codes OR that DMAS return to the use of revenue codes only (by 15 minute unit) since DMAS wants more global coding. Even if you maintain a 93% reimbursement of the MAC rates and we are allowed to use our correct codes, it should not cost DMAS more because the 97110 and the 97530 codes are some of the higher paid codes. However, either option will prevent us from having to change our coding system completely and incorrectly bill for one modality when we document something else. This would also allow us to function in compliance with our standards of ethical practice. We also ask that you attach more value to the important Speech/ Language Pathology Services we provide without reducing the reimbursement for Physical and Occupational Therapy as you have suggested.